STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967419	**10/24/2016**
NAME OF PROVIDER OR SUPPLIER **NUESTRA CASA**	STREET ADDRESS, CITY, STATE, ZIP CODE **1906 NORTH A ST** **LAKE WORTH, FL 33460**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced biennial relicensure survey was conducted on 10/24/2016 at Nuestra Casa (License #11471). The facility had a deficiency at the time of the visit.

Z816 Background Screening-Compliance Attestation

Based on observation, record review, and interview the facility failed to ensure that an attestation of compliance was obtained when accepting a Level II Background Screening that was obtained within the previous 5 years, for 1 of 4 staff (Staff D) records reviewed.

The findings include:

In observations conducted on during the survey, Staff D was observed assisting residents with various activities of daily living, including assisting with self-administration of medications.

A personnel record review conducted on revealed that Staff D, (hire date of) contained an eligible AHCA Background screening result dated // , a further record review revealed that the file lacked an AHCA Form 3100-0008 attestation of compliance with chapter 435, as required.

In an interview conducted on at 3:00 PM with the Administrator, she reviewed the files and confirmed the findings.

Unclassified

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Nuestra Casa
1906 North A St
Lake Worth, FL 33460

RE: Relicensure survey

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

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